Department of Mental Health and Mental Retardation and the Board of Trustees

February 2001

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John G. Morgan
Comptroller

February 22, 2001

The Honorable John S. Wilder
Speaker of the Senate
The Honorable Jimmy Naifeh
Speaker of the House of Representatives
The Honorable Thelma M. Harper, Chair
Senate Committee on Government Operations
The Honorable Mike Kernell, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Department of Mental Health and Mental Retardation. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated,* the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the department should be continued, restructured, or terminated.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dww
99/105

State of Tennessee

Audit Highlights

Comptroller of the Treasury Division of State Audit

Performance Audit
Department of Mental Health and Mental Retardation
and the Board of Trustees
February 2001

AUDIT OBJECTIVES

The objectives of the audit were to determine the authority and responsibility mandated to the department and board and the extent to which the department and board have fulfilled that mandate and complied with applicable laws and regulations; to assess the efficiency and effectiveness of the department's use of resources to accomplish its mission; and to make recommendations that might result in more efficient and effective operation of the department.

FINDINGS

It Appears That Many Mentally Ill Persons Must Be Cared For in State Hospitals Because of a Lack of Adequate Community Services

The department has not ensured that community services adequately meet the needs of the mentally ill. As a result, some patients who are eligible for release stay in a mental institution longer than is necessary (page 16).

A Significant Number of Individuals Incarcerated in County Jails Have a Mental Illness

County jails are the least appropriate environment for the mentally ill. The level and quality of service vary from county to county with some counties providing little or no assistance. There are few programs to divert the mentally ill from the criminal justice system (page 18).

The TennCare Partners Program Has Not Provided a Full Range of Alcohol and Drug Treatment Services for Those Diagnosed With a Combination of Substance Abuse and Mental Health Problems

It appears that TennCare Partners uses treatment guidelines that are not as comprehensive as those offered by the Department of Health's Bureau of Alcohol and Drug Abuse Services. Under the state's contract with the behavioral health organizations (BHOs), substance abuse benefits are limited to inpatient hospital and outpatient substance abuse treatment. The BHOs are required to pay for the treatment of Partners enrollees in a residential treatment facility only when such treatment is deemed "medically necessary" and a "cost-effective alternative." Provider groups and Department of Health staff expressed concerns that the TennCare Partners

program does not offer all services necessary to address the needs of persons with substance abuse problems (page 21).

OBSERVATIONS AND COMMENTS

The audit also discusses the following issues: the utilization of the department's five regional mental health institutes, the Title 33 Revision Commission recommendations, the Memorandum of Understanding transferring oversight of the TennCare Partners program to the Department of Mental Health and Mental Retardation, and the actuarial study regarding the revised consent decree in *Grier et al. v. Wadley et al*. (page 6).

"Audit Highlights" is a summary of the audit report. To obtain the complete audit report, which contains all findings, recommendations, and management comments, please contact

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Performance Audit
Department of Mental Health and Mental Retardation
and the Board of Trustees

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INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

The performance audit of the Department of Mental Health and Mental Retardation and the Board of Trustees was conducted in accordance with the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-221 the Department of Mental Health and Mental Retardation and the Board of Trustees were scheduled to terminate June 30, 2000. As provided for in Section 4-29-111, however, the department and board will continue through June 30, 2001. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the department and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the Government Operations Committees in determining whether the Department of Mental Health and Mental Retardation and the Board of Trustees should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine the authority and responsibility mandated to the department and Board of Trustees by the General Assembly;
2. to determine the extent to which the department has fulfilled its legislative mandate and has complied with applicable laws and regulations;
3. to assess the efficiency and effectiveness of management's organization and use of resources to accomplish the department's mission; and
4. to develop recommendations, as needed, for departmental or legislative action which might result in more efficient and/or more effective operation of the department.

SCOPE AND METHODOLOGY OF THE AUDIT

The policies and operations of the Department of Mental Health and Mental Retardation were reviewed with a focus on procedures in effect during fieldwork, July 1999 to April 2000. The audit was conducted in accordance with generally accepted government auditing standards and included

1. review of applicable legislation and rules and regulations;
2. examination of the department's files, documents, and policies and procedures, as well as the meeting minutes of the Board of Trustees; and
3. interviews with department officials, members of the Board of Trustees, persons employed by the regional mental health institutes, community mental health center staff, behavioral health organization personnel, representatives of relevant advocacy groups, and other state officials.

The performance audit did not cover issues relating to the Division of Mental Retardation Services and the developmental centers because that division was transferred to the Department of Finance and Administration in 1996.

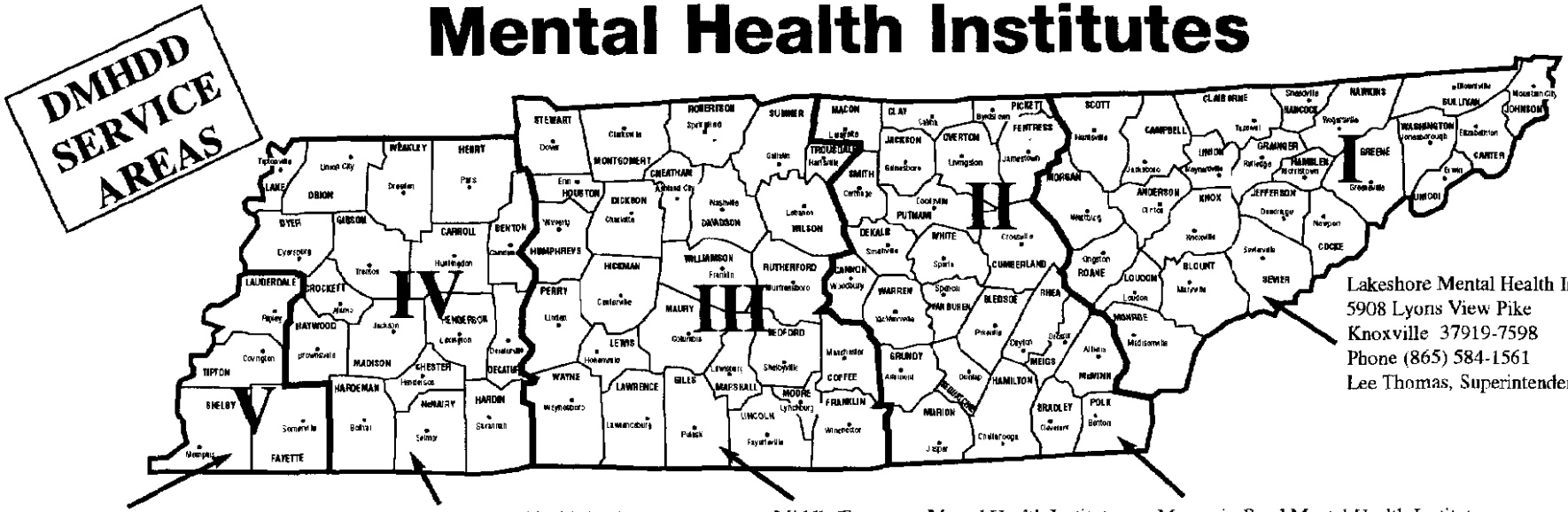
ORGANIZATION AND STATUTORY DUTIES

The Department of Mental Health and Mental Retardation was created by Chapter 27 of the 1953 Public Acts, codified as Section 4-3-1601 et seq., *Tennessee Code Annotated*, to provide services to persons with mental illness and mental retardation. The department operates five regional mental health institutes and three regional developmental centers. (The location of the facilities and boundaries of service areas is shown on the map on page 3.) The Department of Mental Health and Mental Retardation consists of two divisions—Administrative Services and Mental Health Services. The department also maintains offices of General Counsel, Human Resources, Information and Education, Information Services, Licensure, Policy and Planning, and the Developmental Disabilities Council. (See the organization chart on page 4.) The department contracts with community mental health centers and mental retardation agencies for a variety of services.

In fiscal year 2000 the department had 2,570 full-time positions and spent approximately $159 million. In 1996, the department was restructured with the introduction of the TennCare Partners program, supervised by the Bureau of TennCare. However, while the Bureau of TennCare has maintained responsibility for fiscal and budgetary matters, supervision of the Partners program was transferred to the department as of January 31, 2000, in a Memorandum of Understanding signed by the commissioners of Mental Health and Mental Retardation and Finance and Administration. (See observation and comment on page 12.)

Services at Arlington Developmental Center and community services in West Tennessee are subject to the remedial order issued by the U.S. District Court for the Western District of Tennessee in 1994. The remedial order is overseen by a court-appointed monitor. On September 30, 1996, the U.S. District Court for the Middle District of Tennessee issued a Settlement Agreement between People First, the United States, and the State of Tennessee for individuals suffering from mental retardation. This agreement designated "a class consisting of all persons who currently reside or will reside at Clover Bottom Developmental Center, Greene Valley Developmental Center, and all persons who have resided there at any time since December 1992." Community services in Middle and East Tennessee were also subject to the terms of the settlement. This agreement was approved in July 1997. A Quality Review Panel

Mental Health Institutes



Lakeshore Mental Health Institute
5908 Lyons View Pike
Knoxville 37919-7598
Phone (865) 584-1561
Lee Thomas, Superintendent

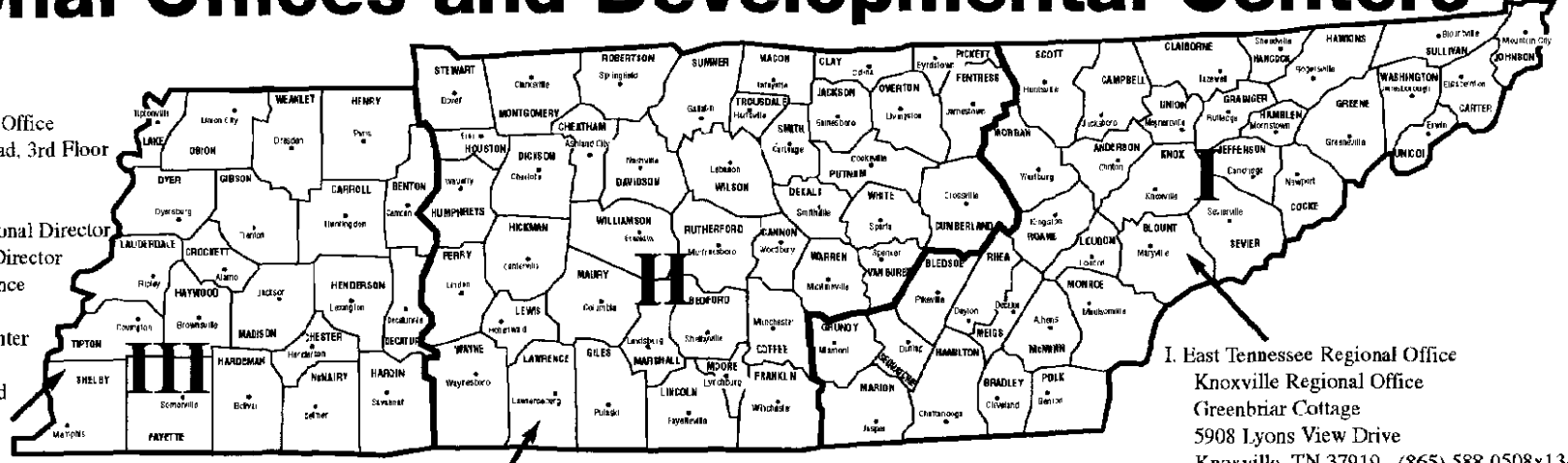
Memphis Mental Health Institute
865 Poplar Avenue, P. O. Box 40966
Memphis, 38174-0966
Phone (901) 524-1200
Thomas Sellars, Superintendent

Western Mental Health Institute
Highway 64-West
Western Institute, TN 38074-9999
Phone (901) 228-2000
Elizabeth Littlefield, Superintendent

Middle Tennessee Mental Health Institute
221 Stewarts Ferry Pike
Nashville 37243-0980
Phone - (615) 902-7400
Joseph Carobene, Superintendent

Moccasin Bend Mental Health Institute
Moccasin Bend Road
Chattanooga 37405
Phone (423) 265-2271
Russell Vatter, Superintendent

Regional Offices and Developmental Centers



III. West Tennessee Regional Office
1341 Sycamore View Road, 3rd Floor
Memphis, TN 38134
(901) 685-3901
Bernard Simons Jr., Regional Director
Rick Campbell, Deputy Director
Commission on Compliance

Arlington Developmental Center
P.O. Box 586
11293 Memphis-Arlington Rd
Arlington, TN 38002-0586-
(901) 745-7200
Pete Davidson, Interim Superintendent

II. Middle Tennessee Regional Office
Nashville Regional Office
275 Stewarts Ferry Pike
Nashville, TN 37214 - (615) 231-5048
Janet Simons, Regional Director

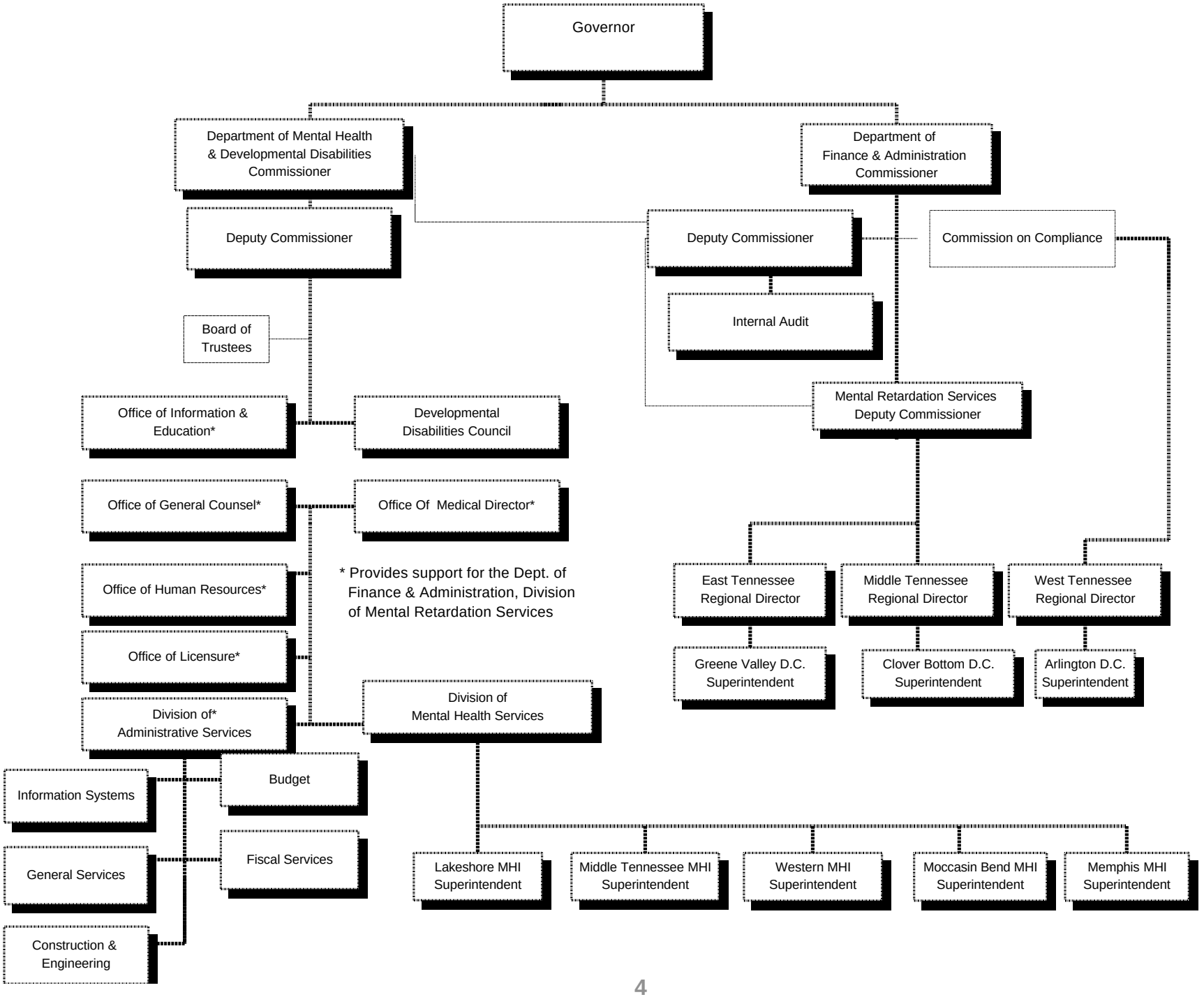
Clover Bottom Developmental Center
275 Stewarts Ferry Pike
Nashville, TN 37243-0970 - (615) 231-5000
Frances Washburn, Superintendent

I. East Tennessee Regional Office
Knoxville Regional Office
Greenbriar Cottage
5908 Lyons View Drive
Knoxville, TN 37919 - (865) 588-0508x134
John Gavin, Acting Regional Director

Greene Valley Developmental Center
P.O. Box 910, 11E Bypass
Greeneville, TN 37744-0910 - (423) 787-6800
Henry Meece, Ph.D., Superintendent

November 2000

Tennessee Department of Mental Health and Developmental Disabilities
August 2000



monitors the settlement agreement. The Division of Mental Retardation Services, all three developmental centers, and their attached community services offices were placed under the supervision of the Department of Finance and Administration by Executive Orders 9 and 10 in February and October 1996, respectively.

BOARD OF TRUSTEES

Created by *Tennessee Code Annotated*, Section 33-1-101, the Board of Trustees for the department consists of 25 members appointed by the Governor for eight-year terms, as well as four *ex officio* members—the Governor, Lieutenant Governor, Speaker of the House, and commissioner of the Department of Mental Health and Mental Retardation. Members are to represent the general public and the two service divisions (Mental Health Services and Mental Retardation Services). The board functions primarily as an advisory body to the department, and its decisions are not binding on department officials. However, the board may pass resolutions expressing to the department the consensus of opinion within the board's membership.

The board met two times in 1999 and twice during 2000. The members discussed the implementation of various policies affecting the TennCare Partners program; revisions to Title 33 (the sections of *Tennessee Code Annotated* dealing with mental health and mental retardation); and persons with co-occurring disorders (patients suffering from both mental illness and substance abuse problems). During fiscal year 1999-2000, there were nine vacancies on the board, with the terms of four additional members set to expire June 30, 2000. Of the 12 appointed members, 8 were female and 4 were male; 9 were white and 3 were African-American.

The recommendations submitted by the Title 33 Revision Commission and passed by the General Assembly in June 2000 included a provision proposing the abolition of the departmental Board of Trustees. The current board's final scheduled meeting is planned for December 8, 2000. Effective March 1, 2001, the departmental Board of Trustees is to be replaced by a Statewide Planning and Policy Council, composed of members representing each of the regional planning councils. The membership is to consist of 17 members appointed by 4 *ex officio* members—the Governor, Lieutenant Governor, Speaker of the House of Representatives, and the commissioner of the Department of Mental Health and Mental Retardation. The Lieutenant Governor and the Speaker of the House each have the power to appoint one legislator as a member of the council. The Governor is to appoint the chairperson of the council. Of the members from each service area, two shall be service recipients or family members of service recipients; one shall be a representative for children; one shall be a service provider; and one shall represent other affected persons within each service area. The commissioner of the department is also to appoint one representative for elderly service recipients and at least three at-large council members. Members who serve on the current departmental Board of Trustees are eligible for appointment to the newly created Statewide Planning and Policy Council.

OBSERVATIONS AND COMMENTS

The issues discussed below did not warrant findings but are included in this report because of their effect or potential effect on the operations of the Department of Mental Health and Mental Retardation, and the potential impact on persons placed in the department's care. These persons include those treated at one of the regional mental health institutes, as well as those receiving treatment through a contracted community mental health service provider.

UTILIZATION OF THE STATE'S FIVE REGIONAL MENTAL HEALTH INSTITUTES

The Department of Mental Health and Mental Retardation operates five regional mental health institutes (RMHIs) across the state. The facilities and their locations are as follows: Lakeshore Mental Health Institute, Knoxville; Middle Tennessee Mental Health Institute, Nashville; Western Mental Health Institute, Bolivar; Moccasin Bend Mental Health Institute, Chattanooga; and the Memphis Mental Health Institute, Memphis. There are 200 beds at Lakeshore, 283 at Middle Tennessee, 247 at Western, 172 at Moccasin Bend, and 98 at Memphis. While each facility is responsible for providing services to individuals located in their respective region, individuals may receive treatment from other facilities.

Each of the state's RMHIs provides a variety of services to the mentally ill. Such services include acute care, rehabilitation, alcohol and drug treatment, forensic services, geropsychiatric services, children and youth programs, extended care, and psychosocial treatment. According to department staff, the data on patient utilization is available on a daily basis and is used primarily as a management tool. Federal regulations proscribe the number of patients that may be served by treatment programs in each facility. The size of each mental health institute and its staff also dictate the number of patients that may be treated. Patients may be classified in more than one treatment category; further, patients' legal status may differ from their treatment status.

The TennCare Partners program was introduced July 1, 1996, as the mental health component of the TennCare managed care program for those persons eligible for Medicaid, as well as the uninsured and uninsurable populations. The Partners program arose out of the managed care organizations' inability to provide adequate mental health services to those enrolled in TennCare. The primary purpose of TennCare Partners was to reduce the number of patients in state-funded mental health institutes, as well as those residing in private hospitals, by enhancing community services resources. However, from 1997 to 1999, four of the five regional mental health institutes experienced an increase in their patient population. The table below indicates the weekly average number of patients for each facility.

Facility	Average Weekly Number of Patients			
	July-Dec. 1996	Calendar Year 1997	Calendar Year 1998	Calendar Year 1999
Lakeshore	209	177	190	194
Middle Tenn.	255	238	241	265
Western	256	236	226	239
Moccasin Bend	145	145	150	150
Memphis	80	100	95	94
TOTAL	945	896	902	942

According to department staff, the increase is largely attributed to patient recidivism, an influx of first-time patients, and the closure of a number of private mental health care providers. Staff also reported that the closures resulted in the state institutes having to serve a number of patients formerly served by private providers. The average number of patients in all the regional mental health institutes for the first six months of calendar year 2000 was 914; however, from July through October, the average daily census had climbed to 965. As of October 29, 2000, the number of patients housed in the state's regional mental health institutes was 991, higher than when the TennCare Partners program was introduced.

Department officials, facility staff, and various advocacy groups suggested that some of the regional mental health institutes might be serving patients not suitable for an institutionalized environment. As noted in Finding 1 (page 16), many persons remain confined in a regional mental health institute due to a lack of adequate placements in the community. Also, department staff reported that, as managed care for mental health and substance abuse treatment has been implemented, the "safety net" provided by the state has been utilized more than when the TennCare Partners program was first introduced. According to various department officials, the department would prefer that the regional mental health institutes serve as the "safety net" only for those patients most in need of acute care, with community mental health agencies providing care for all remaining patients.

This view was also expressed in the "Master Plan for Mental Health Services in Tennessee," published in 1992, which recommended the relocation of as many persons from institutions into community placements as possible. The Master Plan saw the need for only 582 total beds distributed among three regional mental health institutes. The plan concluded that "Tennessee appears to have significantly more institute beds than it would need if adequate community support services . . . were available throughout the state." The Master Plan has not been updated since it was first published in 1992. Department staff reported that the Master Plan was developed prior to the implementation of the TennCare Partners program. Hence, implementation of many of the provisions included in the 1992 Master Plan has been delayed or

suspended, including the target population of 582 institute beds. With the passage of revisions to *Tennessee Code Annotated* dealing with the treatment of the mentally ill and the developmentally disabled, the department is required to develop and update a three-year plan as a basis for budget requests. As part of this plan, the department should determine the ideal number and type of beds needed in the regional mental health institutes.

TITLE 33 REVISION COMMISSION RECOMMENDATIONS

On June 14, 2000, the General Assembly passed legislation embodying the recommendations proposed by the Title 33 Revision Commission. The commission was appointed by Governor Sundquist in October 1998 to develop a thorough revision of those sections of *Tennessee Code Annotated* dealing with the treatment of the mentally ill and developmentally disabled. In February 1997, the administration had submitted legislation to the General Assembly in which it proposed to consolidate the operations of the Department of Mental Health and Mental Retardation and the Department of Health. (That legislation was withdrawn in May 1998.) The Bureau of TennCare was administratively attached to the Department of Health when the legislation was submitted. Many persons in the treatment community, joined by various advocacy groups, requested that the Governor appoint a commission to study those sections of *Tennessee Code Annotated* dealing with the treatment of the mentally ill and developmentally disabled. The Governor signed the revisions into law on June 23, 2000. The name of the department was changed to the Department of Mental Health and Developmental Disabilities on the date the Governor signed Public Chapter 947. Other revisions to Title 33 are effective March 1, 2001, except those provisions dealing with eligibility for developmental disabilities, which take effect March 1, 2002. Central office staff reported that those revisions dealing with mental retardation issues would be implemented March 1, 2002, as part of the Title 33 law covering developmental disabilities.

The goals of the commission were stated as follows:

- To reflect the philosophy of the state to provide services in the least restrictive environment and most typical settings consistent with the needs and choices of the persons served.

- To promote equitable availability of quality services and efficiency in service delivery, and assure appropriate due process safeguards for consumers.

- To assure fiscal and programmatic accountability to consumers and the public with public involvement and oversight.

The main themes of the commission's work, reflected in the recommendations for legislative revision, included the following:

- A commitment to meaningful inclusion of consumers and their families in all aspects of planning, developing, and monitoring of service systems.

- An expectation for the state to develop and maintain community-based systems comprised of a broad array of public and private services and supports. These are contrasted with the prominence of institutional services in current Title 33.

- Early identification of needs, prevention, and early intervention services and supports as preferred responses for people with mental illness, serious emotional disturbance, and developmental disabilities.

- Accurate and responsible accountability for the use of public resources by the department based on outcomes and other forms of accountability.

- Authority for the department to set quality standards for services provided for people with mental illness, serious emotional disturbance, and developmental disabilities regardless of the provider or government agency with responsibility.

- Commitment to children's issues and structures for interagency cooperation to improve service delivery systems for children.

Beyond these changes, the commission listed numerous recommendations within six sub-categories. These included

- recommendations for the entire system of care for the mentally ill, mentally retarded, and developmentally disabled;

- recommendations for mental health services;

- recommendations for developmentally disabled services;

- legal issues spanning laws in addition to Title 33;

- recommendations directed to the administration; and

- recommendations directed to the department.

Among the more prominent components were the following:

<u>System-Wide</u>

1. Codify a philosophy of community-based services to support people with mental illness, serious emotional disturbance, and developmental disabilities in settings that foster each person's sense of dignity and ability to thrive.

2. Maintain citizen-based planning and policy development to advise the department about maintenance and improvement of service systems, tying those plans to the department's budget request.

3. Require the department to set and enforce a basic quality standard for all services to people with mental illness, serious emotional disturbance, and developmental disabilities.

4. Recognize the special status of children with serious emotional disturbance and those with developmental disabilities.

5. Extend licensure requirements to services as well as the facilities that offer them.

6. Adopt civil penalties as an additional remedy for violations of licensure rules.

7. Recognize that the provisions of the recommendations do not create or imply an entitlement to services.

Mental Health Services

1. Authorize new services for people with mental illness who are experiencing severe impairment, permitting observation, assessment, and treatment for 24 to 72 hours when psychiatric certification is given.

2. Require mandatory prescreening for all hospitalizations for people whose services are publicly funded.

3. The extension of requirements for treatment review committees to all treatment resources that serve people who are involuntarily committed. The treatment review committees should assist in decision-making about treatment, confidentiality, etc.

4. Permit alternative transportation agents for patients whose hospitalization is involuntary, provided the mandatory prescreening agent or certifying physician clears the person for medical and security concerns. This is designed to alleviate the need for total reliance on sheriffs' departments.

5. Provide mental health patients the opportunity to specify advance directives for mental health treatment to be administered during periods when they are unable to state their preferences.

Developmental Disabilities Services

1. Expansion of coverage of Title 33 to people with developmental disabilities other than mental retardation.

2. Independent review of admissions to residential services for people suffering from mental retardation.

3. Mandatory community-based services for mentally retarded persons charged with a crime, incompetent to stand trial, and not committable to an institution.

4. Permit decisions about medical and dental services by surrogates for adults with developmental disabilities due to mental impairment.

Legal Issues Which Span Laws in Addition to Title 33

1. Include laws about alcohol and substance abuse in Title 33.

2. Establish uniform confidentiality requirements and disclosure provisions for all human service professionals.

3. Exclude mental health residential treatment facilities from the Certificate of Need law.

4. Review and/or remove reimbursement schedules in *Tennessee Code Annotated*, Section 8-21-901, concerning the amounts sheriffs' departments are paid to transport patients whose hospitalization is involuntary.

5. Change the name of the department to the Department of Mental Health and Developmental Disabilities.

Recommendations to the Administration

1. Promote access to community-based mental health services as the most dignified, humane, and responsible approach to treating mental illness.

2. Prioritize coordination of services for children, youth, and their families. Promote planning and policy development for all vulnerable children in Tennessee.

3. Re-examine the need for surrogate decision-makers for other vulnerable people, and design a comprehensive law regarding surrogate decision-making.

4. Minimize duplicative monitoring of service providers funded by multiple state agencies.

Recommendations to the Department

1. Provide for mental health crisis training for law enforcement officers and transportation for individuals with mental illness.

2. Assist people in transition from age-based services to the next age-appropriate services.

3. Establish inter-divisional agreements for persons with co-occurring mental health issues and developmental disabilities.

4. Promote suitable housing options for consumers.

5. Promulgate rules in certain areas to support Title 33, including administration of psychotropic medications for children; confidentiality; conflict resolution; functions of

Treatment Review Committees; reimbursement; 24-72 hour observation, assessment, and treatment; civil penalties for licensure violations; and surrogate decision-making.

The department should strive to fulfill the responsibilities embodied in the Title 33 legislative revisions by the dates specified for the new mental health and developmental disabilities code provisions. Many provisions became effective when the legislation was signed in June 2000. Other provisions are effective March 1, 2001, while the provisions dealing with eligibility for developmental disabilities are effective March 1, 2002.

THE MEMORANDUM OF UNDERSTANDING TRANSFERRING OVERSIGHT OF THE TENNCARE PARTNERS PROGRAM FROM THE BUREAU OF TENNCARE TO THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

The TennCare Partners program was introduced July 1, 1996, as the mental health and substance abuse component of the TennCare managed care program for those persons eligible for Medicaid, as well as the uninsured and the uninsurable populations. The Partners program was primarily intended to reduce the number of patients in publicly funded mental health institutes, as well as privately funded hospitals, by enhancing community resources. Each managed care organization (MCO) was required to contract with one of the two behavioral health organizations (BHOs) to provide the mental health and substance abuse services covered under the TennCare waiver. The BHOs provide services through contracted providers, much like the MCOs. Included in the provider network are the community mental health centers and the regional mental health institutes. As of June 2000, there were two behavioral health organizations—Premier Behavioral Systems, LLC, and Tennessee Behavioral Health, Inc. As part of the proposed merger of the Department of Health and the Department of Mental Health and Mental Retardation, management of the TennCare Partners program was transferred from the Department of Mental Health and Mental Retardation to the Bureau of TennCare in September 1997. After the withdrawal of the merger proposal during the legislative session which ended in May 1998, the Department of Mental Health and Mental Retardation and the Bureau of TennCare began negotiating the transfer of the TennCare Partners program back to the department. According to a Memorandum of Understanding between the Bureau of TennCare and the Department of Mental Health and Mental Retardation, administration of the TennCare Partners program was transferred back to the department effective January 31, 2000. However, oversight responsibility for the Partners program, including payment to providers and data processing, was to remain with the Bureau of TennCare.

Under the provisions of the Memorandum, the Bureau of TennCare maintains overall supervision of the program and retains the right to make all final decisions affecting the Partners program. Department staff indicated that while the department assumes responsibility for developing programs and policies for TennCare Partners, Bureau of TennCare officials will continue to have final authority over all financial and budgetary matters affecting the Partners program. As of November 2000, department officials reported that the transfer of supervisory responsibility for the Partners program was incomplete. According to staff, only 5 of 12 positions requested by the department have been transferred to the department from the Bureau of TennCare.

The department is authorized to develop specific policy proposals and recommend specific quality indicators in assessing the effectiveness of the TennCare Partners program. The department is also responsible for the development and assessment of "best practice" guidelines for major mental health illnesses and for training personnel employed by the behavioral health organizations (BHOs). In addition, the department is to implement a plan integrating TennCare's services with non-TennCare services to create a continuum of programs available to persons seeking treatment for mental illness.

Further, the department is to review the BHOs' provider networks on a monthly basis and oversee their quality monitoring plans. Other duties include the development and oversight of a system in which TennCare applicants and enrollees who have been diagnosed with severe and/or persistent mental illness or serious emotional disturbance are identified as the "Priority Population." The Department of Mental Health and Mental Retardation is also responsible for identifying, determining the eligibility of, and enrolling the following groups for treatment under the TennCare Partners program: "certified uninsurables" (individuals with severe and persistent mental illness or severe emotional disturbance who have been classified by the department as unable to obtain insurance); "State-only's" (individuals who are not eligible for TennCare Partners but are in need of emergency inpatient psychiatric or substance abuse treatment); and "Judicials" (those persons committed by court order to the care of a regional mental health institute). According to the terms of the Memorandum, the Bureau of TennCare also delegated to the department the authority to evaluate the work of First Mental Health, Inc., the external quality review organization (EQRO) which conducts performance evaluations of the behavioral health organizations for the TennCare Partners program.

Finally, the department agreed to the following: submitting an implementation plan, including specifics as to how the various activities included in the Memorandum of Understanding will be carried out; submitting written quarterly reports summarizing progress in attaining the goals of the memorandum; and participating in monthly meetings at TennCare.

ACTUARIAL STUDY REGARDING THE REVISED CONSENT DECREE IN *GRIER ET AL. V. WADLEY ET AL.*

On October 26, 1999, the plaintiffs in *Grier et al. v. Wadley et al.* entered into a revised consent decree with the Department of Finance and Administration, Department of Human Services, and the State Attorney General. This consent decree placed new requirements on Premier Behavioral Health (Premier) and Tennessee Behavioral Health (TBH), the behavioral health organizations (BHOs) that provide hospital inpatient and outpatient services related to treatment and custodial care for mental health and substance abuse conditions to TennCare enrollees. TennCare pays TBH and Premier a fixed annual premium to provide coverage for the treatment of mental health and substance abuse patients. The TennCare Partners program pays the BHOs approximately $32 million per month for a yearly total in excess of $380 million. The terms of the consent decree were to go into effect November 1, 2000.

The revised consent decree required the BHOs to implement the following procedures:

1. to continue or reinstate benefits during an enrollee's appeal of an adverse BHO ruling;
2. to provide beneficiaries with a written notice of their right to appeal an adverse action;
3. to provide annual notice to all enrollees of their right to appeal;
4. to pay for any service provided by a network mental health/substance abuse physician until a denial of this service has been upheld through the appeal process;
5. to notify enrollees of any adverse action within two business days of any adverse action; and
6. to base all adverse actions on specific characteristics of the individual beneficiary instead of generic standards or norms.

As a result of the transfer of supervision of the TennCare Partners program from the Bureau of TennCare to the Department of Mental Health and Mental Retardation, the department has developed monitoring mechanisms in conjunction with the Bureau of TennCare to evaluate the BHOs' compliance with the requirements of the revised consent decree. After the parties entered into the revised consent decree, Magellan Behavioral Health, Inc., contracted with Arthur Andersen LLP Life and Health Actuarial Services group to perform a limited-scope actuarial study for mental health and substance abuse services provided by the two BHOs, both of which are subsidiaries of Magellan Behavioral Health. The purpose of the study was to estimate the financial implications of the consent decree on TBH and Premier. Arthur Andersen LLP published its report February 18, 2000.

According to the authors of the actuarial study, the revised consent decree appears to increase treatment costs to the BHOs by "substantially minimizing the effectiveness of the utilization management programs of the BHOs." In addition, the consent decree requires Premier and TBH to implement several new administrative procedures. For example, the BHOs must issue an annual notice of the right of all members to appeal in connection with any adverse actions.

The study estimated that the revised consent decree could increase benefit costs by approximately 15% to 20% above the current level of costs, or $40 million to $53 million (midpoint $46.5 million). The actuarial study found that if the TennCare premium is increased by a benefit cost allowance of $46.5 million, and an allowance of 11.75% of premium for administrative expense and premium tax is added, the total premium increase would be approximately $52.7 million.

In conclusion, Arthur Andersen LLP recommended that Magellan consider three options: developing a mechanism to monitor the potential impact of the consent decree; requesting an immediate increase to the current level of funding for the TennCare program to cover the cost increases; and in the absence of funding relief, requesting termination of its TennCare contract.

The department has contracted with PriceWaterhouseCoopers to perform an actuarial study examining the funding mechanisms for implementation of the requirements contained in the revised consent decree. The purpose of the study is to improve the department's ability to assess the adequacy of community services, as well as to independently examine the financial

implications for implementing the revised consent decree. Additionally, the BHOs have conducted training sessions for all staff at the state's five regional mental health institutes, as well as those employed by private mental health care providers. These training sessions include instruction on the proper care and treatment of patients under the provisions of the consent decree. Further, the Department of Health, the Department of Finance and Administration, and the Department of Human Services are instructed "to enter into an agreement with the Comptroller of the Treasury to monitor all aspects of compliance with this order." The Comptroller is "to have access to any and all records, documents, or personnel needed to ascertain compliance," and must also submit quarterly reports to the state agencies responsible for implementing the terms of the revised consent decree.

The department should ensure that mental health and substance abuse services promised to TennCare Partners enrollees in the revised consent decree are not compromised and that the treatment of enrollees is not disrupted during appeals of adverse actions by the BHOs.

FINDINGS AND RECOMMENDATIONS

1. It appears that many mentally ill persons must be cared for in state hospitals because of a lack of adequate community services

Finding

The Department of Mental Health and Mental Retardation has not ensured that community services adequately meet the needs of the mentally ill. As a result, some patients who are eligible for release are forced to stay in a mental health institution longer than is necessary. Moreover, the lack of community services may increase the likelihood that mentally ill individuals will have problems with law enforcement and enter the criminal justice system.

Section 504 of the 1973 federal Rehabilitation Act required the states to provide treatment to the mentally ill in the least restrictive environment possible. In July 1990, Congress passed the Americans with Disabilities Act requiring all states to provide treatment to the mentally ill in the least restrictive environment possible. In response, the Tennessee Department of Mental Health and Mental Retardation began to de-emphasize the role of the state's five regional mental health institutes (RMHIs) and turned to the development of a system of privately funded community mental health providers. Those patients who have been stabilized and are no longer considered a threat to themselves or others are categorized as suitable for placement in an outpatient community treatment program. Further, the department's plan stipulated that patients were to receive needed mental health services at community service agencies, with only the most difficult cases remaining in one of the state's mental health institutes.

However, according to department staff, including representatives from each of the state's five mental health institutes, a lack of community services has forced some patients eligible for release to stay in a mental health institute longer than necessary. Eligibility for discharge is dependent upon an evaluation by medical staff who determine the fitness of patients for release to a less restrictive environment. Patients are denied discharge if the needed community service is not available. For example, staff at one mental health institute reported that there were as many as 20 patients eligible for release who were not discharged due to a lack of appropriate community support services. Although patients retain the right to receive needed assistance from community agencies in other regions of the state, they seldom choose this option because of difficulties associated with traveling long distances. Further, until November 2000, central office and field staff reported that the department had not conducted a study to assess the type, number, location, and cost of needed services. According to these officials, as well as many in the mental health treatment community, necessary funding to develop adequate community support services has not been made available. Therefore, the department and the behavioral health organizations have been unable to provide comprehensive community mental health services to persons in all parts of the state. The Bureau of TennCare, which is responsible for monitoring the adequacy of the BHOs' treatment networks, has found that some areas do not have an adequate number of residential treatment facilities and inpatient services for both adults and children.

In addition, a lack of sufficient community services may also increase the likelihood that mentally ill persons will enter the criminal justice system. According to a 1999 study conducted by the State Justice Institute, the proportion of persons with a mental illness in jails throughout the nation is greater than in the general population. Furthermore, department staff and several county sheriffs reported that a lack of community services has increased the likelihood that mentally ill individuals would be arrested. These groups urged an increase in the availability of supervised housing as well as improved case management services for the mentally ill.

Recommendation

The department should conduct a study to ascertain the type, number, and location of needed community services in the state, and take appropriate action to increase the number of providers in areas where community mental health treatment services are most needed. Also, the department should determine the number of persons currently residing in the state's five regional mental health institutes who are eligible for treatment in the community, including those already living in the community who would benefit from increased availability of community-based mental health treatment services.

Management's Comment

We partially concur. TDMHDD (Tennessee Department of Mental Health and Developmental Disabilities) has recognized the need to identify and increase appropriate community based services. To that end we have initiated several activities.

A continuum-of-care work group comprised of staff from the Division of Mental Health Services (MHS), Bureau of Alcohol and Drug Abuse Services, the Office of the Medical Director, and the Office of Consumer Affairs has inventoried the current TennCare and non-TennCare mental health and substance abuse services and programs available throughout the state. The result is a picture of services currently being offered which allows for the identification of gaps and needed services to fill these gaps.

The work group is currently working with a team assigned to review network adequacy to incorporate service locations with the service inventory. This will show the current capacity to provide the services listed and where there are service gaps that need to be addressed. It should be noted that by doing this we will also be working on one of the requirements of the Title 33 revisions, which calls for a needs assessment and listing of services provided in the state.

During 1999, a review process began at Moccasin Bend Mental Health Institute to identify the service needs of the long-term patients in the Winston Building. $1.7 million were approved to use for this process with the ultimate goal of closing the Winston Building. A decision was made to expand the review process to include all long-term patients at the Regional Mental Health Institutes. The reviews are complete at Moccasin Bend Mental Health Institute and Middle Tennessee Mental Health Institute. Plans are to complete this review process at the other three regional mental health institutes by March 2001.

In addition, plans have been finalized for a Targeted Transitional Support (TTS) Program that will provide temporary funding for patients discharged from Moccasin Bend Mental Health Institute, Middle Tennessee Mental Health Institute, and Western Mental Health Institute who are in need of payment for housing, community supports and/or treatment services while their Social Security benefits, TennCare and/or other financial resources are being established.

The Office of Housing Planning and Development of TDMHDD, in conjunction with the United States Department of Housing and Urban Development and the Tennessee Housing Development Agency, have increased the awareness and funding availability for the development of housing across the state of Tennessee. This has been accomplished through the Creating Homes Initiative (CHI), developed and implemented by the Office of Housing Planning and Development. The CHI has resulted in the development of over 1,000 new housing options for Tennesseans with mental illness. In addition, this landmark initiative has been successful in the securing of approximately $14,064,283 new dollars for housing options for persons with mental illness and disabilities. This includes $4,500,000 which will be distributed jointly by TDMHDD and THDA in February 2001.

During fiscal year 1999-2000, the TennCare Partners Roundtable's Inpatient Sub-Committee began studying information on inpatient admissions per region, average length of stay by facility and readmission rates by facility. Discussions focused on how to evaluate the data related to community support and resources, crisis intervention services, housing support, the number of severely and persistently mentally ill in different areas, and the access to services across the state. The committee (now called the Adult Services Committee) will continue to study the data regarding inpatient utilization and measure the impact on consumers, including identifying community services to allow consumers to remain in the community.

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2. A significant number of individuals incarcerated in county jails have a mental illness

Finding

A greater number of the mentally ill are incarcerated in county jails than are patients in the five-state regional mental health institutes combined. As of April 2000, the five mental health institutes had a total population of 933 patients. In contrast, a 1998 survey of county jails by the TennCare Partners Roundtable found that there were 1,890 inmates in pre-trial custody with some form of mental illness. Moreover, respondents to this survey believed that the number of mentally ill inmates is increasing. Specifically, approximately two-thirds of the county jails responding to the survey indicated that the number of incarcerated mentally ill has increased in the past 12 months, with 18% of the respondents reporting an increase of 26% or more. (Although most of the survey respondents were jail officers rather than behavioral health professionals, the Roundtable believed that the lack of specialized training was offset by the respondent's direct observation of and interaction with the incarcerated person.)

As a result of the significant presence of the mentally ill in the criminal justice system, some county jails have taken steps to address their medical needs. Such services have included

the provision of needed medications as well as crisis intervention. However, despite these efforts, department staff and several sheriffs' departments insisted that county jails are the least appropriate environment for the mentally ill. Counties are required to pay for any services mentally ill inmates receive. As such, the level and quality of services vary from county to county with some counties providing little or no assistance. Moreover, some counties do not segregate mentally ill inmates from the general population. Additionally, some jails do not provide training for jail officers who deal with mentally ill inmates. According to a 1999 study by the federally funded State Justice Institute, 66% of county jails do not segregate inmates, while 47% do not provide training specific to working with mentally ill inmates to jail staff.

The large number of incarcerated mentally ill has been attributed to a number of factors. Specifically, the department lacks a comprehensive statewide program to help divert the mentally ill from the criminal justice system. Such a statewide system could assist sheriffs' departments in identifying mentally ill individuals who have been arrested in order to place them in an appropriate environment where they can receive needed assistance. The foremost goal of such a program would be to reduce jail time for those not appropriately confined and connect the detainee to suitable treatment. According to several sheriffs' departments, such a program would also minimize the financial burden borne by counties by reducing the number of incarcerated mentally ill for whom the counties must provide services.

The lack of community services is another factor contributing to the mentally ill inmate population. A mental health advocate and several sheriffs' departments reported that the lack of community services increases the likelihood that a mentally ill individual will be arrested. Community services may help address the needs of the mentally ill before the involvement of the criminal justice system is required. Improved case management services would also reduce the likelihood that persons suffering from mental illness would find their way into the criminal justice system.

The lack of TennCare coverage for discharged jail inmates is a third factor contributing to the mentally ill inmate population. Upon conviction for a felony, individuals lose their TennCare coverage and must reapply once released from jail. However, according to one county jail mental health care provider, it can take months for TennCare coverage to be reinstated. During the interim period, discharged mentally ill inmates do not receive needed treatment. One sheriff reported that while waiting for their TennCare coverage to be reinstated, discharged inmates often get into trouble with the criminal justice system and return to jail.

Recommendation

The department should conduct a study to ascertain the type, number, and location of needed community services to help minimize the possibility of incarceration of mentally ill persons. Additionally, the department should consider establishing a statewide comprehensive diversion program in conjunction with district attorneys general, district public defenders, and the courts.

Management's Comment

We partially concur. The department recognizes the need to assure that mental health services are provided to individuals with mental illness who are in the criminal justice system and to ensure continuity of treatment as they re-enter the community.

In March 1999, Commissioner Rukeyser acted on a recommendation from the Tennessee Mental Health Planning Council and established the Criminal Justice Task Force for the purpose of examining the issues affecting adults with mental illness involved in the criminal justice system. The task force made several findings and recommendations that are included in the Criminal Justice Task Force Report on Mental Health & Criminal Justice in Tennessee. Since this report was published several activities have taken place.

In October 1999, the Task Force submitted a written request to the Bureau of TennCare requesting development of a mechanism that would allow TennCare benefits to be suspended rather than terminated while an enrollee was incarcerated. The response from the Bureau indicated that an internal work group was established to study the request. The Mental Health Services policy group has also addressed this issue and will follow up with the Bureau to determine the status of the recommendation.

In November 2000, the Criminal Justice Advisory Committee was established for the purpose of oversight and implementation of the Task Force recommendations and to monitor how the two systems are progressing toward interacting productively. The Committee serves in an advisory capacity to both the mental health and criminal justice systems. In December of 2000, TDMHDD (Tennessee Department of Mental Health and Developmental Disabilities) established within MHS (Mental Health Services) a position to serve as a criminal justice/mental health liaison for the state. This person coordinates and facilitates the activities of the advisory committee in assessing needs, developing community resources, and monitoring services for this population. The liaison is to assure the Task Force recommendations are addressed and to facilitate communication and coordination between the systems for the purpose of developing community services and promoting education and training.

Eight criminal justice/mental health pilot liaison positions were funded during FY00-01. The pilot projects are located in Madison, Montgomery, Rutherford, Putnam, Bradley, Anderson, and Washington counties. One position is assigned to the 23rd judicial district that includes Houston, Humphreys, Stewart, Cheatham, and Dickson counties. Responsibilities for the liaisons include incarceration, and coordinating communication between the mental health and criminal justice systems. The liaisons are also responsible for developing relationships with sheriffs and for providing education and training to jail personnel and other personnel so that case management services can be provided to incarcerated individuals.

A project to work with the Pretrial Diversion Program was funded for fiscal year 2000-01 in Shelby County. The project provides staff to supervise and perform the activities of a release coordinator and to develop resources (housing) and follow-up services for consumers released through the pre-trial diversion program. The project includes pre-trial diversion activities with the courts and the public defender's office.

The department has contracted with the National Alliance of the Mentally Ill of Tennessee to sponsor and coordinate three regional training sessions with community law enforcement personnel and other interested persons. The sessions are to be conducted during FY01.

The department has contracted with Volunteer Behavioral Systems to develop and conduct education and training activities on the criminal justice system for mental health personnel. These sessions are scheduled in February and March of 2001.

MHS's new liaison has met with the Tennessee Correctional Institute to discuss methods of developing training and education activities. A meeting with the executive board of the Tennessee Sheriffs' Association is scheduled in February 2001 and plans are being made to meet with the Tennessee Association of Mental Health Organizations to discuss the development and provision of cross training activities statewide. The liaison is also a participant on the Davidson County Mental Health Court advisory committee.

Other activities occurring in the state include a pre-trial diversion program through the Shelby County Mayor's office, the Mental Health Court in Davidson County General Sessions Court, a Forensic Assertive Community Team (FACT) through the Mental Health Cooperative, a Jail Liaison between the Mental Health Cooperative and the Davidson County jail, and jail case management services in the Hamilton County correctional facility that involve the availability of mental health personnel to provide case management and training activities.

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3. The TennCare Partners Program has not provided a full range of alcohol and drug treatment services for those diagnosed with a combination of substance abuse and mental health problems.

Finding

It appears that TennCare Partners utilizes treatment guidelines that are not as comprehensive as those offered by the Bureau of Alcohol and Drug Abuse Services within the Department of Health. Under the state's contract with the behavioral health organizations (BHOs), with which the Bureau of TennCare has contracted to provide managed care to those suffering from alcohol and drug problems, substance abuse treatment benefits are limited to inpatient hospital and outpatient substance abuse treatment. Residential treatment is not covered under the contract. The BHOs are required to pay for the treatment of Partners enrollees in a residential treatment facility only when such treatment is deemed "medically necessary," and only when such an approach is deemed a "cost-effective alternative." Provider groups and staff employed by the Bureau of Alcohol and Drug Abuse Services expressed concerns that the TennCare Partners program does not offer all services necessary to adequately address the needs of persons suffering from substance abuse problems. Additionally, they raised concerns that the Partners program may be ignoring the environmental, emotional, and social conditions affecting addiction. Specifically, these groups thought that the BHOs' treatment of substance abuse patients appears to emphasize a medical model in the treatment of Partners enrollees, rather than

the more comprehensive clinical model, which stresses the recovery and rehabilitation of persons suffering from alcohol and substance abuse problems.

Both of these programs share many of the same characteristics, including the treatment of a significant number of persons also diagnosed with a mental illness. However, there are important differences between them. TennCare Partners is designed to treat those with substance abuse problems under a managed care approach, in which capitation rates are paid by the Bureau of TennCare to the behavioral health organizations (BHOs), which in turn pay providers enrolled in the BHO network. As such, Partners enrollees are generally limited to a certain number of inpatient treatment days, and their conditions are measured on the basis of the intensity of their drug and/or alcohol problems.

By contrast, the program operated by the Bureau of Alcohol and Drug Abuse Services is a block grant program. It treats those persons who have lost their TennCare benefits, the indigent, and those who have lost their insurance or whose insurance will not pay for alcohol and drug treatment. Funds used for the block grant program may not be used to reimburse for-profit agencies. This requirement necessarily excludes the behavioral health organizations enrolled in the Partners program. Because the Partners program limits coverage to inpatient treatment, enrollees are not eligible for the wide range of services provided under the block grant program. Therefore, it appears that the care available to TennCare Partners enrollees does not compare favorably to that offered participants in the programs provided by the Bureau of Alcohol and Drug Abuse Services.

Under the Phase III improvements to the TennCare Partners program implemented in 1999, adults requiring residential treatment services would receive those services through the block grant program administered by the Department of Health. This shift of services was intended to fill the void in TennCare's continuum of care. However, central office staff of the Department of Mental Health and Mental Retardation, as well as their counterparts in the Department of Health, expressed concerns about whether the block grant program could accommodate an increased level of usage by those not qualified for the TennCare Partners program.

According to a Memorandum of Understanding between the Department of Mental Health and Mental Retardation and the Bureau of TennCare, the department is responsible for developing specific policy proposals and recommending specific quality indicators in assessing the effectiveness of the TennCare Partners program. The department is also responsible for the development and assessment of the "best practices" guidelines for major mental health illnesses and for training the BHOs. The department is also directed to implement a plan that integrates TennCare Partners' services with non-TennCare treatment programs to create a continuum of care. According to central office staff, in a memorandum signed by the commissioner and dated August 7, 2000, the Department of Mental Health and Mental Retardation formally recommended that the Bureau of TennCare expand its definition of medical necessity. Specifically, the department requested the Bureau include more outpatient treatment services than those currently covered by the TennCare Partners program. In another memorandum dated October 3, 2000, the department submitted amendments, in draft form, to the current BHO contract that are currently under review by the Bureau of TennCare.

Recommendation

The Department of Mental Health and Mental Retardation should seek to implement the provisions of the Memorandum of Understanding with the Bureau of TennCare, which transfers oversight of the TennCare Partners program to the department. An integral part of this oversight should include the development of treatment guidelines integrating substance abuse services offered by TennCare Partners for the mentally ill with those provided by the Bureau of Alcohol and Drug Abuse Services within the Department of Health.

The Department of Mental Health and Mental Retardation and the Bureau of TennCare should work with the behavioral health organizations to establish substance abuse treatment programs for the mentally ill comparable to those provided by the Bureau of Alcohol and Drug Abuse Services. However, if residential treatment is to be provided solely through the block grant program, both the department and the Bureau of Alcohol and Drug Abuse Services should institute better communication between the two programs to ensure that the continuum of care is not disrupted. The Department of Health should further seek to ensure that the treatment of enrollees in the block grant program is not compromised by an infusion of patients released from the TennCare Partners program.

Management's Comment

We partially concur. Currently, the Memorandum of Understanding (MOU) document is in draft contract form and is being finalized between the Bureau and TDMHDD (Tennessee Department of Mental Health and Developmental Disabilities).

Last year, in response to the MOU, TDMHDD formed work groups that began the process of implementing the provisions of the MOU. As stated in Finding 1, the continuum of care work group, which included staff from the Bureau of Alcohol and Drug Abuse Services, has inventoried the current TennCare and non-TennCare services and programs. The continuum that was developed integrates mental health and substance abuse services.

To promote integrated services for the dually diagnosed, TDMHDD and the Bureau teamed with an integrated treatment provider and applied for a Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMSHA/CSAT) Targeted Capacity Expansion grant. The grant has already allowed for the expansion of integrated services to males, initiation of service for females and the initial evaluation of the effectiveness of best-practice treatment approaches for dual diagnosis. In addition, Mental Health Services and the Bureau of Alcohol and Drug Abuse Services have awarded grants to three community mental health agencies to implement integrated treatment/best practices for persons with co-occurring disorders.

In FY2000, MHS division also received a Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Prevention (SAMSHA/CSAP) grant. The grant's

focus is a prevention service for children of dually diagnosed parents. The project provides education and support services to children and families affected by dual disorders of parents. In addition, the grant supports an evaluation of the project.

The Transition Team formed by John Tighe and Commissioner Rukeyser and comprised of staff from TDMHDD, the Bureau of Alcohol and Drug Abuse Services and TennCare, acknowledged that accessing residential substance abuse treatment in the current TennCare Partners benefit package has been problematic and that those with co-occurring disorders have been effected. The team recommended that covered alcohol and drug abuse services need to be specifically defined where medical/clinical necessity criteria is used. When medical necessity is used to determine the need for alcohol and drug abuse services, the definition should support a relapse and recovery philosophy. The recommended benefit package included both residential and outpatient services to all TennCare members based on both clinical and medical necessity up to the lifetime limitation of $30,000.

RECOMMENDATIONS

ADMINISTRATIVE

The Department of Mental Health and Mental Retardation should address the following areas to improve the effectiveness of its operations.

1. The department should conduct a study to ascertain the type, number, and location of needed community services in the state, and take appropriate action to increase the number of providers in areas where community mental health treatment services are most needed. Also, the department should determine the number of persons currently residing in the state's five regional mental health institutes who are eligible for treatment in the community, including those already living in the community who would benefit from increased availability of community-based mental health treatment resources.

2. The department should conduct a study to ascertain the type, number, and location of needed community services to help minimize the possibility of incarceration of mentally ill persons. Additionally, the department should consider establishing a statewide comprehensive diversion program in conjunction with district attorneys general, district public defenders, and the courts.

3. The Department of Mental Health and Mental Retardation should seek to implement the provisions of the Memorandum of Understanding with the Bureau of TennCare, which transfers oversight of the TennCare Partners program to the department. An integral part of this oversight should include the development of treatment guidelines integrating substance abuse services offered by TennCare Partners for the mentally ill

with those provided by the Bureau of Alcohol and Drug Abuse Services within the Department of Health.

4. The Department of Mental Health and Mental Retardation and the Bureau of TennCare should work with the behavioral health organizations to establish substance abuse treatment program for the mentally ill comparable to those provided by the Bureau of Alcohol and Drug Abuse Services. However, if residential treatment is to be provided solely through the block grant program, both the department and the Bureau of Alcohol and Drug Abuse Services should institute better communication between the two programs to ensure that the continuum of care is not disrupted. The Department of Health should further seek to ensure that the treatment of enrollees in the block grant program is not compromised by an infusion of patients released from the TennCare Partners program.